Request for MHS Medically Frail Assessment

Date: ______________________________ Referring Facility: ___________________________________

Provider/Contact Person Phone: ____

Member Name: __________________________________ Member RID: ___________________________

Date of Birth: _____________________ Member Phone Number(s): __________________________

Diagnoses With Dates:

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Inpatient Hospitalizations (Dates and Diagnoses):

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Medications:

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Current Treatment Plan:

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Supporting Documentation Included:

__ Intake Assessment (initial evaluation)

__ Intake Assessment (medical)

__ History & Physical

__ Psychosocial (if not included in initial evaluation)

Please fax to the MHS Medically Frail Department at **1-866-694-3653** or secure email to **Medically_Frail@mhsindiana.com**.